THE FUTURE OF HEALTHCARE: "IT STARTS WITH YOU"

ARKANSAS DEPARTMENT OF HEALTH

OFFICE OF RURAL HEALTH & PRIMARY CARE

CRITICAL ACCESS HOSPITAL ADMINISTRATORS MEETING

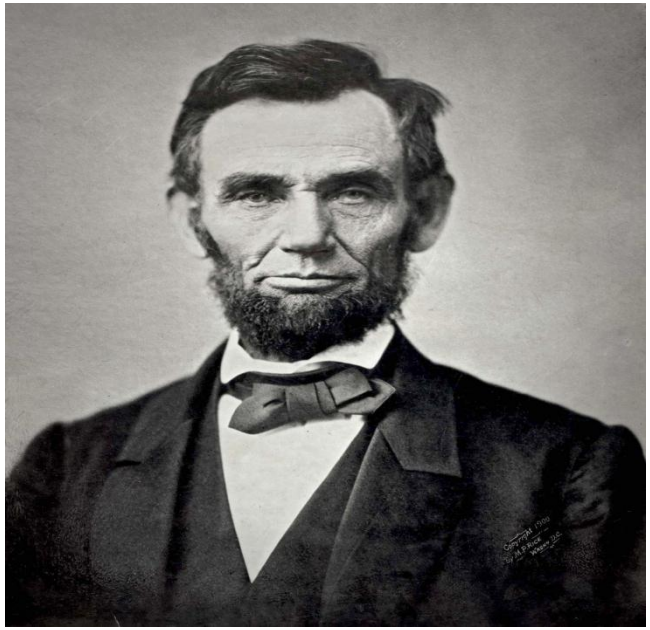
CONNECTED HEALTHCARE SOLUTIONS, LLC

Lance W. Keilers, MBA, CAPPM

September 9, 2014

Give me six hours to chop down a tree and I will spend the first four sharpening the axe.

Abraham Lincoln



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Learning Objectives

- Recognize current changes and obstacles in rural healthcare
- Identify leadership challenges in rural healthcare
- Discover ways to positively impact rural healthcare

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On The **Radar**

- Changing **Environment** and Delivery System – *Healthcare Marketplace…how are you preparing?*
- **Reimbursement** Impact – Rural Programs
- **Care** Transition and Coordination – *clinical inventory of services and strengths and gaps*
- **Community** Connection
- OIG Report – *unfamiliar with rural; can view CAH program as not needed*
  - Value of CAH designation to rural and communities
  - Swell of support/outreach to policy makers
  - Look to the future models

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Rural Healthcare **Environment**

- Affordable Care Act in full swing…new delivery models, expansion of health care and change
  - *Push for Collaboration, Coordination and Consolidation*
- Reimbursement challenges – highly regulatory
- Regional systems chaos
- Mergence of Population Health Management
- Healthcare professionals working to their full scope of practice
- Physician retention – changing model for them
- Consumer/patient expectations
- Transitional Care – a must

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Hospital **Operations**

- ICD – 10 Adoption and comprehensive training
  - Medical records, physicians, clinical staff, ancillary staff, and billing staff…being prepared during transition to 10/1/2014
- Health Information Technology moving to Stage 2
  - Information exchange, security, informatics, on going maintenance and support; upgrades
- Care Coordination – patient and family
  - Care Management
  - Potential for telemedicine
- Quality and Hospital Performance
- Community Health Needs Assessment –*outreach to community*
- Customer Service – importance of employee

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Physician Partnerships

- Physician recruitment and **retention plans/**strategies
- Inclusion in hospital decision-making and part of care management teams; board participation
- Incentive programs includes quality and performance
- Medical staff bylaws
- Training for advanced practice practitioners
- Understanding the hospitalist role
- Nursing and physicians work together
- Top priority for hospitals

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Physician Management Issues

- Requires new hospital and board understanding and management skills
- Expect increase in salaries and decrease work schedule
- Supervision of advance practice providers
- Responsibility for care coordination
- Increased scrutiny/benchmarks
- Changing physician role
- E-health

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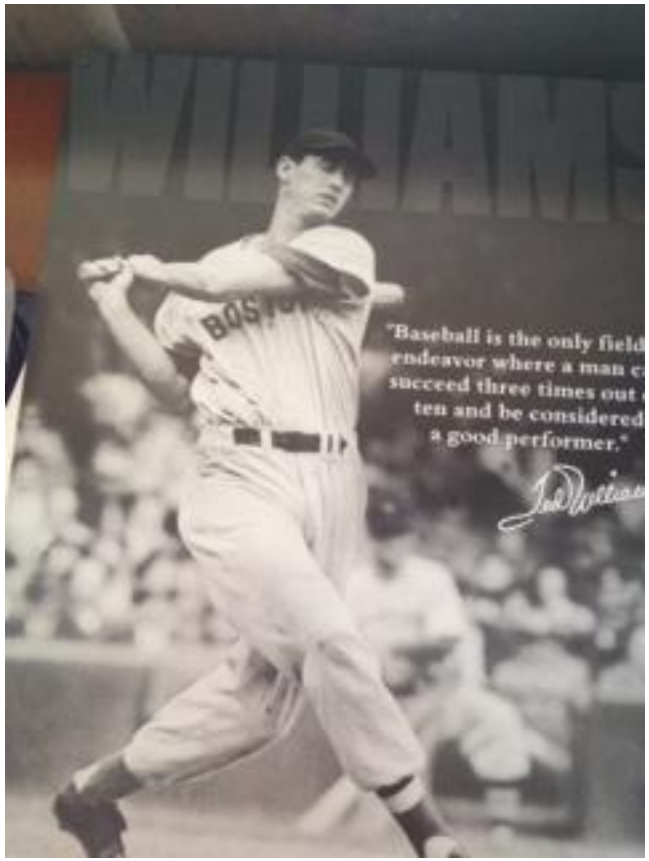
Ted Williams and Life



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OIG Recommendations to CMS

1. Seek legislative authority to remove Necessary Provider CAHs permanent exemption from the distance requirement;
2. Seek legislative authority to include alternative location requirements;
3. Ensure that CMS periodically reassess CAHs for compliance with all of the location requirements;
4. Ensure that CMS applies a uniform definition of "mountainous terrain" to all CAHs (April 2013 reg)

*** CMS concurred with the 1st, 3rd, and 4th recommendation, but not the 2nd.

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Background

- 1,329 CAHs providing care for 2.3 million Medicare beneficiaries.
- Established in BBA 1997. Created by Congress after hundreds of rural hospital closures due to change to PPS payment system.
- CAH = small (25 beds or fewer) and rural (35 miles from another hospital or 15 miles in mountainous terrain or where only secondary roads are available.) Also, 24-hr emergency, average patient stay cannot exceed 96 hours.

- Necessary Provider CAHs: Prior to 2006, states had discretion to designate NP:
- Had to comply with all other COPs, including rural requirement
- At least 40 states developed distinct criteria for a NP CAH
- **75 percent of CAHs are NP CAHs**

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Specific OIG Findings

- 846 CAHs would not meet the distance requirement if required to re-enroll
  - 306 were located 15 miles or fewer to a nearest hospital.
  - 235 were between 10-14 miles from nearest hospital.
  - 71 were less than a 10-mile drive.
  - 3 would not meet the rural requirement.

More Findings

- 50% of hospitals that don't meet distant require were located nearest to another CAH.
- 7% were located nearest to hospitals that did not provide emergency services.

(Flaws: state-line issues, Veteran Administration issues, Indian Health Services)

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What does this OIG report mean?

- If fully implemented; complete crippling of the rural health system.
- 70, 80, even 90% of rural hospitals in certain states impacted.
- Wisconsin: 53 of the state's 58 CAHs would lose their CAH status.

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Even if not fully implemented

- 10-15 mile CAHs in great jeopardy

AND MAYBE MORE!!

President Obama's 2015 Budget Proposal

- Cuts to CAHs
- AHEC funding reductions
- Reimbursement cuts from 101% to 100%
- CAH 10 mile rule
- Flex grant line cut by 15 million dollars
- Bad debt cuts

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They just don't get it!

HHS Report Would Create Huge Voids in Access to Health Care in Rural America.

- The 34-page report of Critical Access Hospitals would eradicate individual state determinations on which small, rural hospitals are critical "necessary providers" in a state;

Critical Access Hospitals are critical to the rural economy.

- Critical Access Hospitals create approximately 138,000 jobs.
- Critical Access Hospitals are often the largest or second largest employer in a rural community.

The HHS report is wrong. Eliminating Critical Access Hospital does not save money. CAHs save tax payer dollars.

- Despite Critical Access Hospitals representing over 22% of all community hospitals, Medicare expenditures to CAHs are less than 5% of the Medicare hospital budget

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Rural Health Works Findings

- Economic impact of closing the 846 CAHS would be:
  - 209,808 in lost jobs; and
  - over **$8.7 Billion** in wages, salaries and benefits to the communities that they serve.
- A far cry above the $449 Million in savings that the OIG reported.

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The Impact of CAHs In Rural America

- It was estimated, using IMPLAN software in the study, that for every 10 people employed by a CAH, an additional 7.6 jobs depends indirectly on the economic activity of that CAH, reflecting a 1.76 employment multiplier.
- A similar study completed in Oklahoma by the National Center for Rural Health Works claimed the impact of closing one CAH would result in the loss of 107 jobs and have an income impact of $4.8 million.
- When the national average employment multiplier of 1.36 and average income multiplier of 1.2 are used the total jobs lost is 146 and the income impact is $5.9 million (Peton, 2011).

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The Cost of Care In Rural America

Investing in rural care is cost-effective:

- The Federal investment in rural hospitals benefits both the rural patient and the tax payer. In fact, rural hospitals provide care for **18 percent** of all inpatient, outpatient and long-term Medicare patients, yet receive only **15 percent of Medicare expenditures.**

- Further, small, rural hospitals nationally have equal or better quality outcomes, and **cost 3.7 percent less** per Medicare beneficiary than their urban counterparts.

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“Do what you can-

with what you have-

where you are”

Theodore Roosevelt

1858-1919

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Healthcare is changing!

- ACOs
- Physician/staff shortages
- Swing from inpatient care to outpatient care
- Regulatory burdens
- Reimbursement cuts

*Rural CEOs are stressed out and frustrated!

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Kansas Survey

Job Stress

Has your job stress and difficulty increased in the past two years?

• *Greatly*	*32.2%*	*19 responding*
• *Very Much*	*33.9%*	*20 responding*
• *Somewhat*	*25.4%*	*15 responding*
• *A Little*	*5.1%*	*3 responding*
• *Not at All*	*3.4%*	*2 responding*

Jody M. Gragg RN,BSN,MICT

Is Rural Healthcare Leadership at Risk?

An Assessment of the Administrators of Kansas Critical Access Hospitals

August 22, 2012

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Kansas Survey

Hospital Closure

- *10.2 % of responding administrators stated that there was either a "Very Good" or "Good" chance of closing in the next five years.*
- *27.1% stated “Somewhat" and*
- *33.9% said a "Small" chance.*

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2013 Hospital Closures

According to Becker's Hospital Review, 18 hospitals closed in 2013.*

Rural hospitals included:

- Corcoran District Hospital (California)
- Cozby-Germany Hospital (Texas)
- Charlton Memorial Hospital (Georgia)
- Stewart-Webster Hospital (Georgia)

*Becker's Hospital review January 2, 2014 by Bob Herman

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2014 Hospital Closures

- Lower Oconee Community Hosp. (Georgia)
- Tilden Community Hosp. (Nebraska)
- Vidant Pungo Hosp. (North Carolina)
- Mid-Valley Hosp. (Pennsylvania)
- Nicholas Co. Hosp. (Kentucky)
- Good Shepherd Medical Center (Texas)
- North Adams Reg. Hosp. (Massachusetts)
- Lake Whitney Med. Ctr. (Texas)
- Gibson General Hosp. (Tennessee)

UNC Sheps Center hospital closure website

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Reasons for Closures

- Medicare/Medicaid reimbursement cuts
- Pending loss of CAH status
- 2% cut in Medicare reimbursements
- Low patient usage
- Cash flow problems
- Uninsured population

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Kansas Survey

Chance of Hospital Merging

- *25.4% responded Yes.*
- *40.7% responded No.*
- *33.9% responded Maybe.*

59.3 % of administrators agree that there is at least a chance of merging in the future.

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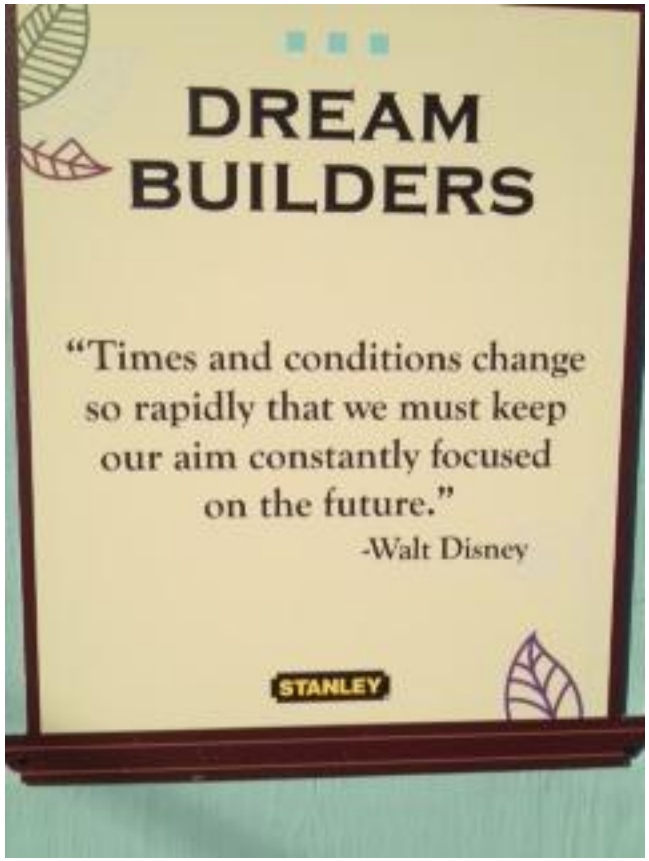
Change Happens



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We have to huddle up and get in the game!

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Rural Relevance; How Do We Maintain It?

1) Leadership
2) Vision and Strategy
3) Partnerships and focus on the community
4) Use of data and information
5) Efficient and effective operations

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1. Leadership

1. Educate & engage the hospital board
2. Align hospital leaders & managers around value-based strategies
3. **Lock in physicians & other primary care providers**

Leadership is critical to helping organizations understand the "WHY" of needed change.

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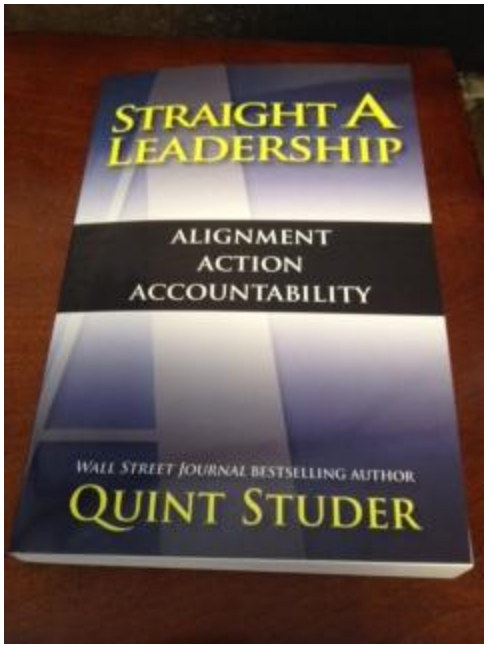
Leadership Resources



- Alignment
- Action
- Accountability
- Leadership Consistency and Best Practices

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Leadership Characteristics

- Demonstrates Leadership
- Advocacy
- Building Trust
- Communication
- Change Management
- Decision Making
- Executive Presence
- Innovation
- Interpersonal Skills
- Relationship Building
- Talent Management
- Value and Leverage Diversity
- Vision

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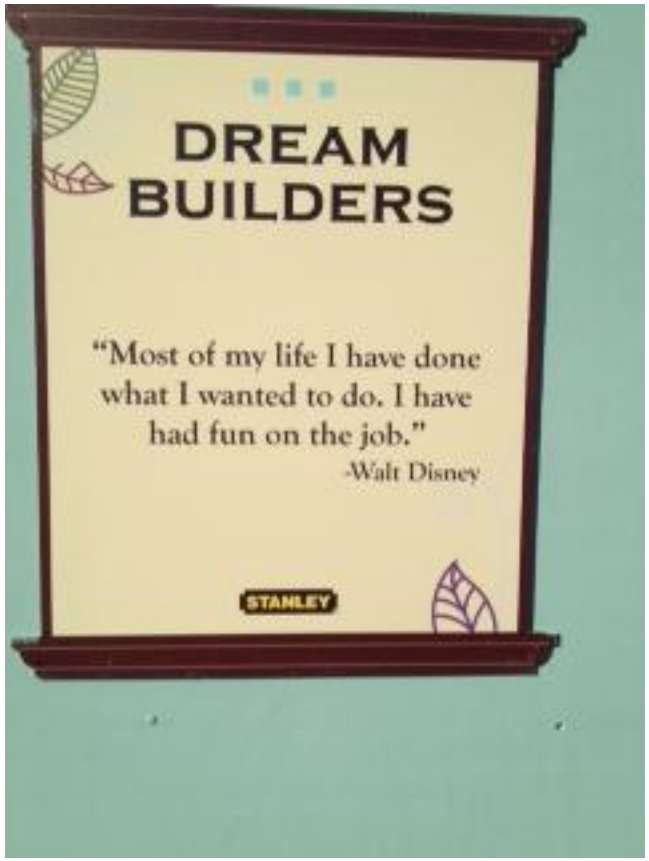
Enjoy What You Do!



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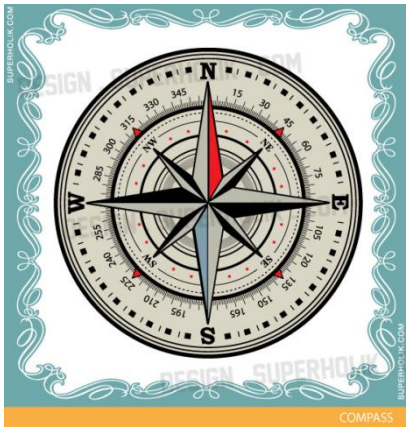
2. Vision and Strategy

4. Engage in meaningful strategic planning at least annually
5. Use a systems framework for planning to ensure a holistic approach
6. Communicate the plan organization-wide in easy to understand language



Your strategy map needs to be clear and easy to understand with a balance between long and short term goals.

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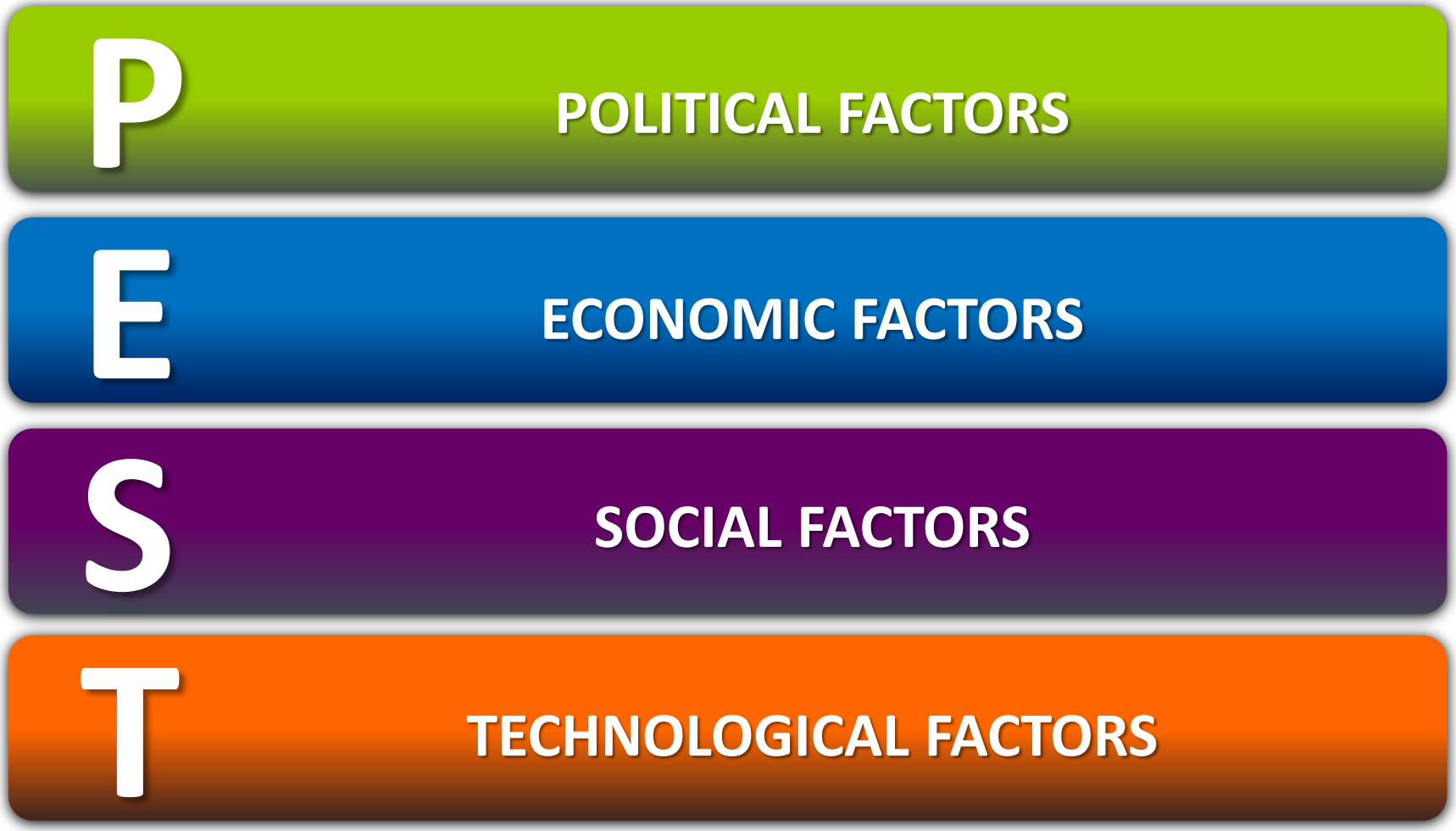
Pest Analysis



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3. Partnerships and Focus on the Communities

7. Measure and publicly report patient satisfaction and **excel at customer service**
8. Explore partnerships with larger systems or rural networks
9. Explore partnerships with other types of providers in the service area
10. Engage and educate the community to encourage use of local health services

We need to turn stakeholders into partners.

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Partnerships and Focus on the Communities

We need to engage the community in a way that they truly feel they add value.

It is easy to get feedback from our patients, we need input from our *community.*

Start small – focus on employee health improvement, or one primary issue in your community.

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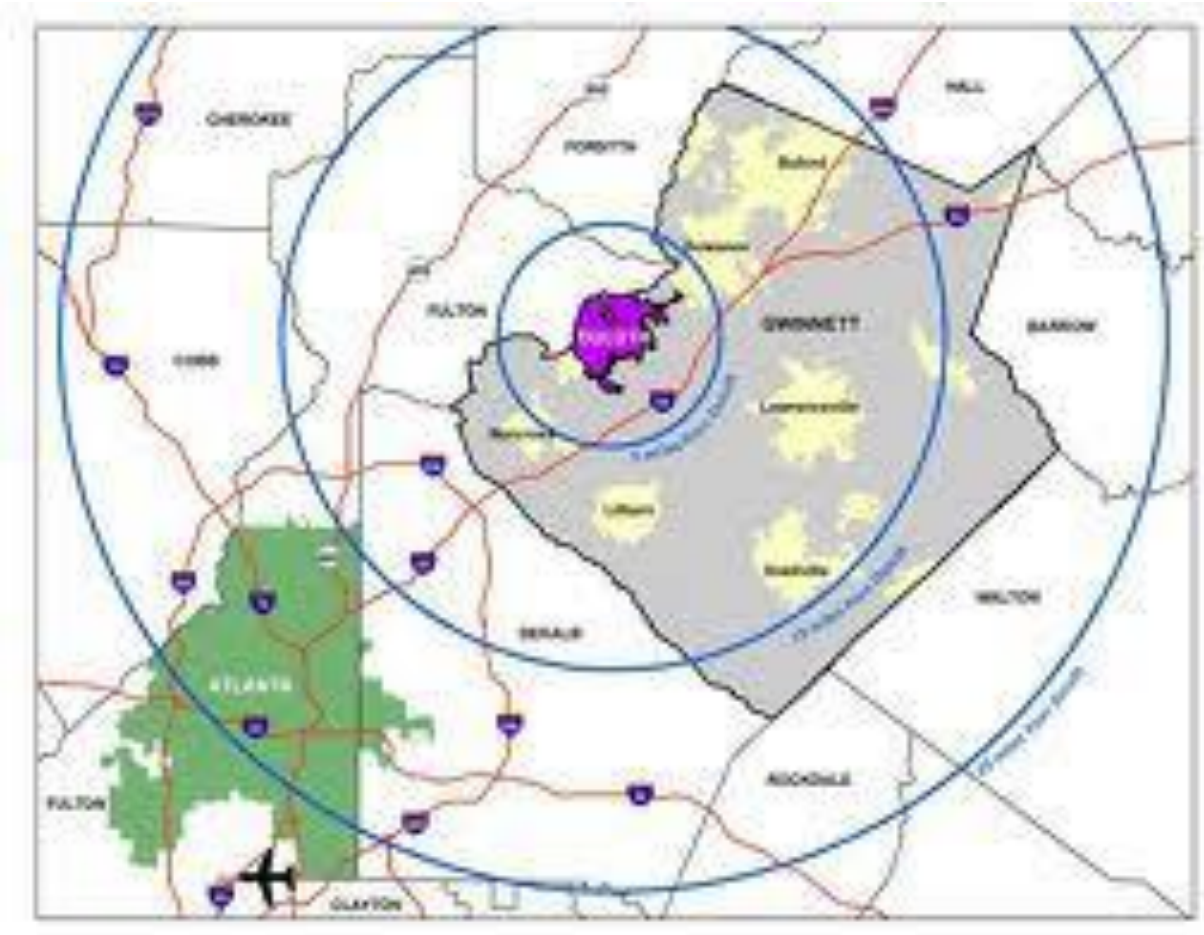
Goal: Capture Full Market Share



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A Change in Perspective is Needed; Population Health & Care Coordination

- Focusing on population health requires us to think differently about leadership

- *If you don't help your community to thrive and grow –how will your organization thrive and grow?*

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Listen To The Community

- The solutions to population health and care coordination challenges lie with mobilizing resources not found in the healthcare system, but rather among the community's assets.

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Listen To The Community

- Participate in collaborative relationships aimed at improving overall health

"This is not about hospitals fixing all the problems –but engaging with other leaders in the community to address the problems"

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Build The Case for Population Health

- Create alignment towards value-based reimbursement
- Frame the conversation in terms of charity care, bad debt, and community benefit
- Identify the impact on other priorities (recruitment/retention, satisfaction, care transitions)

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Look Inside Your Own Walls

Apply employee wellness programs

- Implement case management/care coordination services for employees with chronic conditions

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What is Population Health?

Any provider arrangement with a payer in which you agree to provide care to a defined group of people (the population) in which you must do 3 things:

1. Improve the group's medical outcomes
2. Reduce the group's per-capita costs
3. Contractually capture the savings from the value you've created in 1 & 2

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Successful Population-Health Business Models

4 REQUIREMENTS

1. Focused commitment on PCP care coordination, improved quality, and reduced per-capita cost—i.e., producing patient value
2. Non-FFS payer reimbursement that incentivizes & rewards patient value
3. PMPM cost measurement and management
4. Actuarially credible population size:
   - **THE central problem for individual rural & CAH population health revenue models**

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Put Population Health on the Agenda

Review claims data to identify service area priorities

- Answer the following questions:

–How does population health align with strategic initiatives and health reform activities?

–What is your role in addressing the two aspects of population health (cohort/community)?

–What are next steps to implementing/integrating population health strategies?

–What community needs are a priority and how do they impact the hospital?

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Reach Out To The Community

Don’t wait to be asked

- Build on CHNA results and monitor progress
- Support staff involvement in community task forces
- Articulate roles/responsibilities in supporting community efforts
- Think beyond traditional partners
- Be patient; changing culture takes time

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4. Measurement, Feedback and Knowledge

11. Use a strategic framework to manage information and knowledge
12. Evaluate strategic process regularly and share information organization-wide
13. Gather and use data to improve the health and safety of patients in the service area

Measurement takes the politics out of management and drives performance.

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The Future of Reporting Data

- CAH quality reporting requirements will continue to increase
- Quality reporting will be market/payer driven (even in small rural hospitals)
- Payment reform on a national level will impact CAHs through data submission

❖CAHs should be proud of the care we deliver

❖We should always strive to improve patient care

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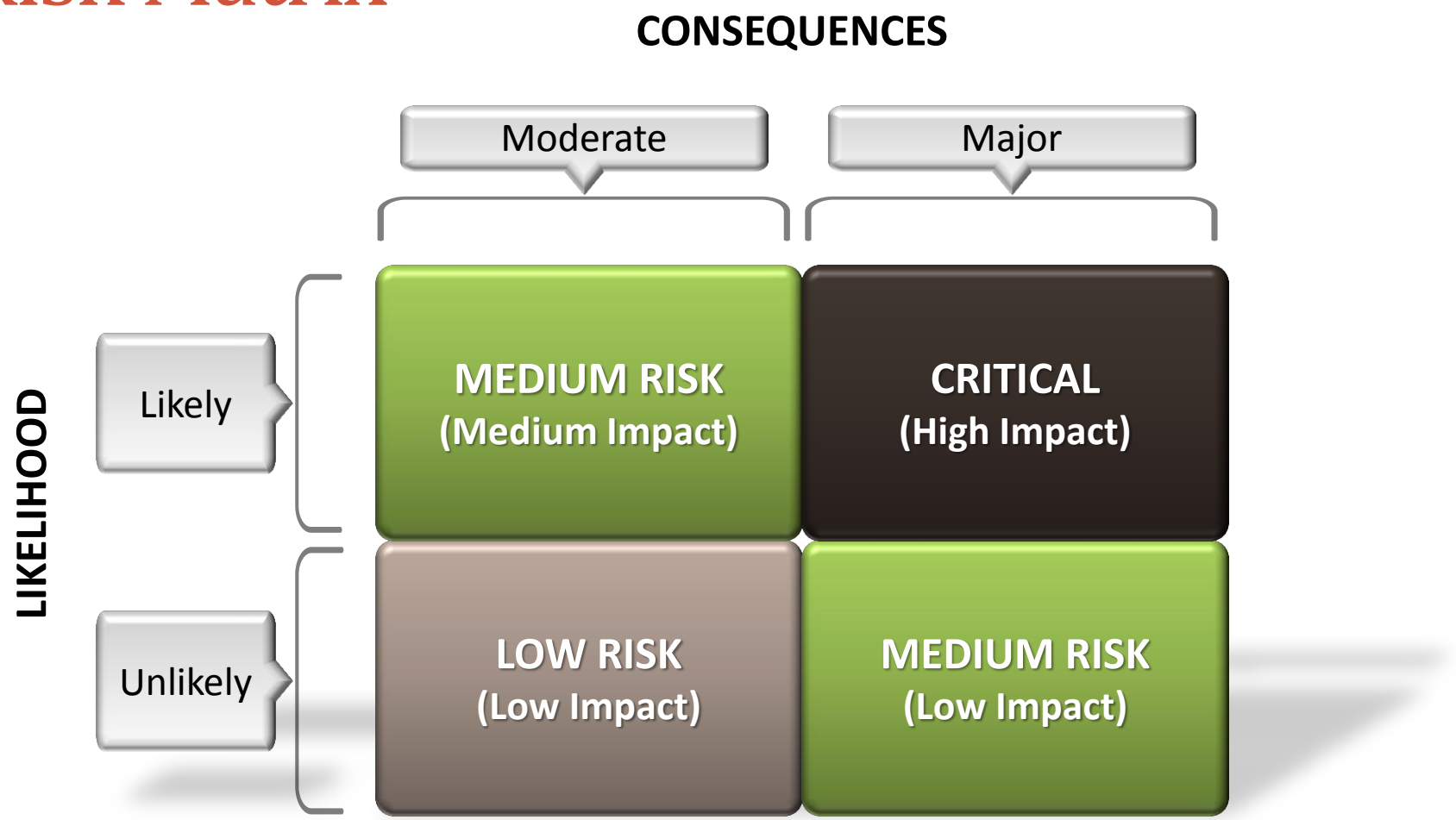
Risk Matrix



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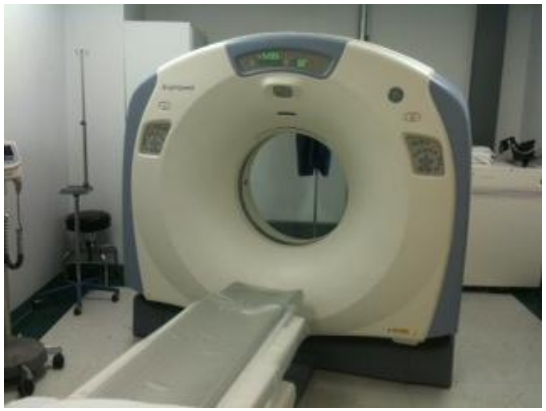
5. Operations and Processes

14. Develop efficient business processes and maximize revenue cycle management
15. Continually improve quality and safety processes
16. Use information technology to improve both efficiency and quality



Unless we execute on these, our survival is in jeopardy.

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Balanced Scorecard

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“The best thing about the future is that it comes only one day at a time”

Abraham Lincoln

1809-1865

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Healthcare is Changing!

Triple Aim

- Better health
- Better care
- Lower cost

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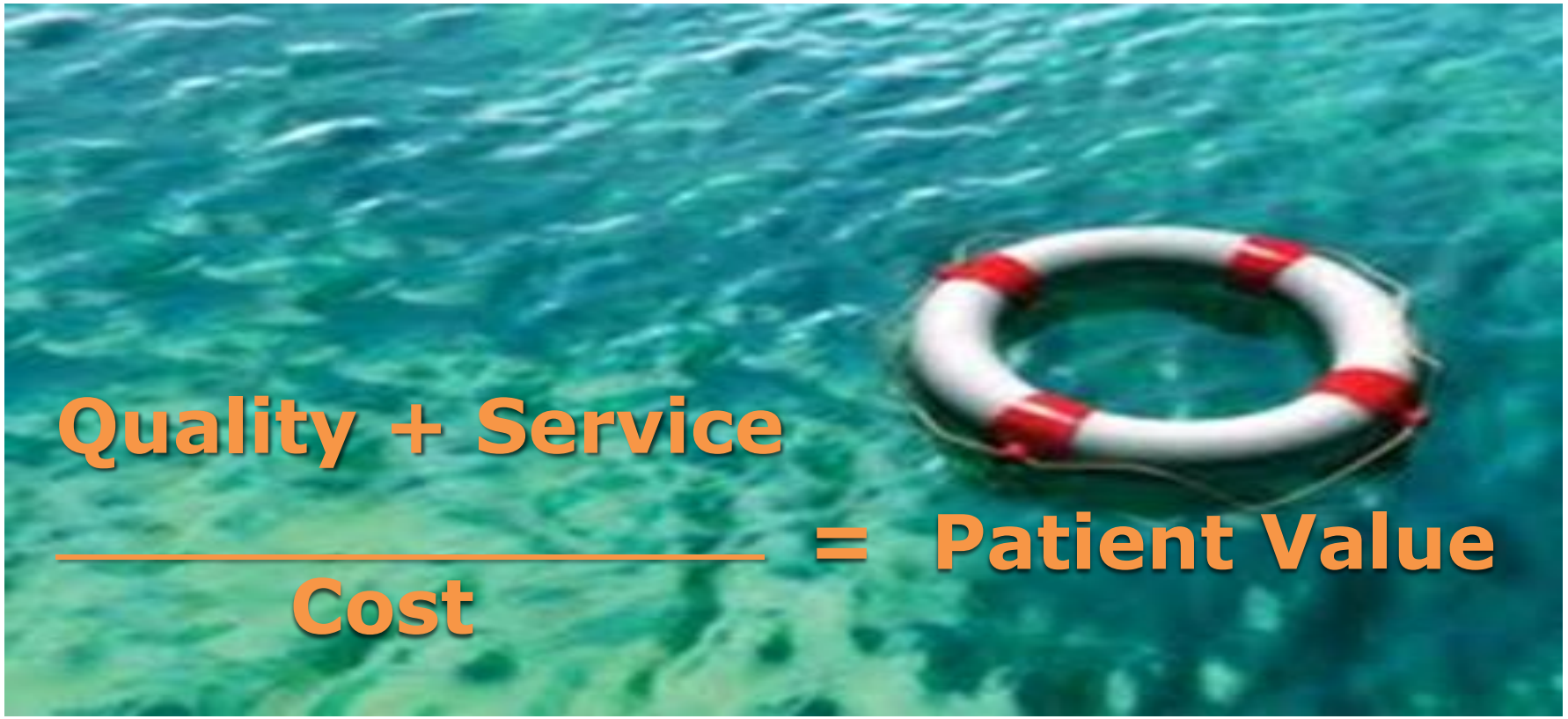
Future Healthcare is Based on Value



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We can’t stand on the sidelines!

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Ongoing Rural Leadership Challenges

- Continued difficulty with recruitment of providers
- Increasing competition from other hospitals and physician providers for limited revenue opportunities
- Requirement that information technology is on par with large hospital systems
- Rural hospital governance members without sophisticated understanding of rural hospital strategies, finances, and operations

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Ongoing Rural Leadership Challenges

- Severe limitations on access to capital of necessary investments in infrastructure and provider recruitment
- Increased burden of remaining current on onslaught of regulatory changes
  - *Swing Bed*
  - *96 Hour Rules*
  - *10 Mile Rule*

  –Regulatory Friction / Overload
- Payment systems transitioning from volume based to value based

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“To reach a port, we must sail-
sail, not tie an anchor-
sail, not drift”

Franklin Roosevelt
1882-1945

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Documents To Become Familiar With

The Financial Performance of Rural Hospitals and Implications for Elimination of the Critical Access Hospital Program

George M. Holmes, George H. Pink,
and Sarah A. Friedman
University of North Carolina at Chapel Hill

NRHA Presentation, May 8, 2013

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Documents To Become Familiar With

Medicare, Swing Beds, and Critical Access Hospitals

Kristin L. Reiter, George M. Holmes and Ila H. Broyles

Med Care Res Rev 2013 70: 206 originally published online 21 October 2012

The online version of this article can be found at:

http://mcr.sagepub.com/content/70/2/206

Published by:

http://www.sagepublications.com

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The future!

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What do you want your community to know about YOUR hospital?

- ✓Small Does Not Mean Insufficient or Unaccomplished!
- ✓Limited Services Does Not Mean You're Lacking in the Area of Technology, Advances in Medicine or a Vision for Improving and Enhancing Services!
- ✓Family and Emergency Medicine at Your Hospital **IS** a Front Door to a World of Healthcare for the Community!
- ✓Every member of the Your Hospital Team is Committed Excellence when it Comes to Serving and Caring...Everyone they Come into Contact with!

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The future!

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The future!

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As Leaders We Must Decide

- Decide to be DELIBERATE
  - Be strong
  - Be resolute
- Decide to be a DREAMER
  - Take action
- Decide to be DEVOTED
  - Be committed
  - Give your all

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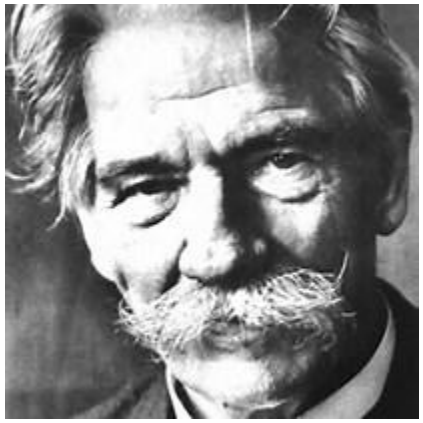
“Success is not the key to happiness.
Happiness is the key to success.
If you love what you are doing,
You will be successful.”

Albert Schweitzer
1875-1965



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QUESTIONS???

Thank you!

Lance W. Keilers, MBA, CAPPM
President
Connected Healthcare Solutions, LLC
lwkeilers@connectedhcsolutions.com
(325)212-2143

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